Remarks of
CONGRESSMAN HENRY A. WAXMAN

to the
COLLEGE OF AMERICAN PATHOLOGISTS
Friday, March 20, 1992

I'm glad to be able to join you today to talk about some key health-related concerns Congress will face this session.

For the first time in many years, health care is one of the most prominent issues in the public mind, and the opportunity for change may finally be upon us. This is a timely meeting; this is a period of great discontent about America's health care system, and a time when Washington is filled with discussion about what to do to respond.

As you know, I chair the House Subcommittee with primary responsibility for Federal health programs, and the range of issues we work on is broad. This year we will:

* continue to fight the battle to save family planning programs from the conservative strait-jacket that would stop a doctor from even talking to a patient about what her medical options are;

* we will work to lift the ban on NIH research using fetal tissue, research that has the potential to find cures and treatments for diseases like Parkinson's, diabetes, and Alzheimer's. Rather than acknowledging that abortion exists and using the fetal tissue in the same way as one would use an organ for transplant, the NIH is forbidden even to study this field;

* and we hope to see enactment of legislation that will reduce toxic exposure to lead, the number one environmental health threat to children in America. This legislation will provide for lead screening programs and reduce the possibility of lead contamination through drinking water, paint, soils and food.

While these issues are the bread and butter of my Subcommittee's work, today I'd like to focus my remarks on two issues of major concern to you right now: the on-going changes in Medicare policy, and the prospects for health care reform.

Too often in Washington, the sad fact is that most of the health care fights have nothing to do with health care policy -- they have to do with money. The battles are about budgets and deficits and financing schemes and taxes. And just as often, the debaters forget about doctors and hospitals and patients and disease.

While the Bush Administration has brought in the kinder and gentler rhetoric, it has a Reagan-like health agenda that divides services from payment, and pits payors against providers.

Medicare

Again this year, the Bush Administration seems determined to use the Medicare program as a primary source for budget savings. Despite a 5-year budget agreement in 1990 calling for Medicare cuts of $42 billion, the President obviously thinks the program is ripe for further reductions.

The President's February budget recommends a Fiscal Year 1993 cut in Medicare of $1.2 billion. For the most part, these cuts would come at the expense of increased out-of pocket costs for beneficiaries and further reductions in payments for anesthesia, laboratory tests and durable medical equipment items. In addition, the President would like to charge user fees to hospitals and nursing homes -- shifting the costs of determining compliance with Medicare's Conditions of Participation to providers.

I can see no coherent health policy behind this disparate collection of proposals. I can only conclude that this budget is just a continuation of the blind, arbitrary budget-driven policies that have characterized the past 12 years of the Reagan-Bush Administrations.

What is even more disturbing is the Administration's apparent desire to use Medicare and Medicaid caps as a primary source for financing his ill-conceived plan to create tax credits for low income persons to buy health insurance.

While the President has -- as yet -- been understandably reluctant to submit a detailed plan on how these caps would be applied, it is astonishing to me that he would consider cutting the Medicaid program to finance tax credits and deductions.

Equally disappointing in the President's budget is the absence of any proposals to improve benefits or limit the rapidly rising costs of care faced by the elderly and disabled. The cost-effectiveness of preventive services has been well documented, and yet many of these services are still not covered by Medicare. Outpatient prescription drugs are also a steeply rising out-of-pocket cost for the elderly, particularly those who are unable to afford private supplementary insurance or are not poor enough for Medicaid eligibility. Nothing in the President's budget addresses these shortcomings in Medicare.

As you all know, these budget proposals come on the heels of last year's attempt to use the new Medicare Fee Schedule as a device for cost-cutting. After working long and hard with the physician and beneficiary communities to reach agreement on a budget-neutral fee schedule, we spend considerable time last year pressuring the Administration to follow congressional intent -- an effort that was frustrating and only partially successful in the end.

I was outraged, as you were, that last year's proposed rule to implement the fee schedule from HHS so clearly ignored both the letter and spirit of the agreement on physician payment reform.

That whole affair, in my view, damaged the credibility of the Federal government by willfully disregarding both congressional intent and the clear understanding of physicians that the fee schedule would not become a tool for across-the-board reductions in physician payments. It is never easy or painless to engage in fundamental policy reforms -- as we are seeing in the unfolding debate on health reform -- more about that in a minute. In this case, Congress, physicians, and the beneficiary community made significant compromises with the expectation that the final agreement would be fairly implemented and that both the Nation's elderly and disabled and physicians would be better served.

I want to particularly recognize the constructive participation of the pathology community in working with Congress and the Administration in the development of the fee schedule. I am sure that many of you are wondering now whether your involvement in this process was a wise move. I recognize that the cumulative effects of budget cuts over the last four years and other features of the new RB-RVS fee schedule have resulted in significant reductions in Medicare pathology payments.

Let me assure you that I intend to monitor carefully the impact of the fee schedule and to consider further refinements to assure that all physicians are treated fairly. One area that certainly merits further review is whether the fee schedule adequately recognizes the costs of practice that physicians face. You probably know that practice costs have not been treated in the same manner as the value of physicians' work. We are looking at recommendations from the Physician Payment Review Commission (PPRC) about how to improve the accuracy and fairness of practice cost adjustments.

As you may know, the Health Care Financing Administration has requested medical specialty groups to provide comments on problems with the relative values and on other matters. These comments will be the basis for modifications to the fee schedule during the phase-in period. I urge you to communicate your specific recommendations concerning the payment for pap smear interpretations and the allowance for the technical components of pathology services. I would also suggest that you share these recommendations with the PPRC as well.

There is no question that these physician payment reforms represent dramatic changes for you. It is equally evident that we will need to make changes as we gain experience with this ambitious undertaking.

While the pressure put on the Administration last year by the Congress and the provider community caused some changes to be made in the fee schedule, much of our effort was blocked by budget policy. That is, to enact legislation to force HCFA back to the policy we originally intended was estimated to cost billions of dollars. And, that's the great frustration we face when the budget drives policy. So it couldn't be done without breaking that ill-conceived budget agreement or covering the costs by cutting Medicare elsewhere.

Meanwhile, I want you to know that I am committed to further improvements in Medicare, especially to expand coverage for cost-effective preventive services, and to provide coverage for prescription drugs -- as I stated earlier. It will not be easy to find the resources for these initiatives, but I believe the failure of Medicare to provide coverage of preventive services costs us much more than the dollars necessary to pay for these benefits.

Our Subcommittee will also be working to extend the authority for the Agency for Health Care Policy and Research.

This agency -- the focal point of the federal government's efforts to support research on medical effectiveness and patient outcomes -- is a critical part of the physician payment reforms enacted in 1989. It is the agency responsible for working with physicians and other health professionals in the development and dissemination of clinical practice guidelines. You may have seen the first set of these guidelines on pain management that were released last week.

In these times of tight budgets, it is even more important to have good information about what works best in medical care, and what services provide little benefit to patients. Otherwise, we are even more likely to be forced into arbitrary, budget-driven policies that interfere with physician judgement and deny patients medically appropriate care.

As we review the Agency's work to date, we will need your advice about the research agenda and how best to interpret and apply research findings. Obviously, it's critical that these activities enjoy the support of practicing physicians and those who depend on Medicare to finance their care.

Health Care Reform

Finally, let me discuss briefly with you the current state of discussions on health care reform. We've spent the past twelve years waiting for the invisible hand of the marketplace to solve these problems by itself. You know as well as I do that it hasn't.

It's obvious to me that if we continue to do nothing, then things will just get worse. There will be:

-- continued high inflation in the price of medical care,
-- more and more uninsured Americans,
-- higher and higher premium costs for small and large employers,
-- more and more out-of-pocket costs for workers and their families,
-- larger and larger burdens on the elderly and the Medicare program,
-- greater and greater pressure on Federal and State Medicaid budgets,
-- and, if the Bush Administration has its way, more shifting of costs from the Federal government to States and localities.

The Bush Proposal

The Bush Administration finally seems to recognize that the health care crisis in this country is serious.

After three years in office, it has come out with a proposal for what the President thinks of as "comprehensive reform."

He's way off the mark.

The American people want four things from health care reform:

-- protection against the high costs of care,

-- guaranteed coverage for basic services,

-- choice of their own doctor,

-- and a way to pay for it that is fair, doesn't hurt American competitiveness, and does not take benefits away from the elderly and the poor.

The Bush 'plan' flunks each of these tests. It's not reform. In fact, I think its main goal is to provide political cover for a thinly-veiled attempt to cut Federal spending on the elderly and the poor.

Just recently, Robert Reischauer, the Director of the Congressional Budget Office, testified before the Congress on the President's proposals. He concluded that, and I quote, these proposals "are unlikely to slow the rate of growth of health spending." In fact, Mr. Reischauer said, "a few of the cost control strategies put forth could actually raise costs."

In other words, the President's proposal does nothing to control rising health care costs. It won't help large employers become more competitive in the global marketplace. It won't make health insurance cheaper for small employers. It won't protect workers and their families from high out-of-pocket costs. In fact, it could well make matters worse.

The President's proposal also won't do much to help 36 million uninsured Americans get basic health care coverage. The President is offering refundable tax credits of up to $1,250 for an individual and up to $3,750 for a family of 3 or more, available to families with low incomes.

However, as CBO points out, a substantial number of people would not elect to use the tax credits to purchase insurance, because the amount of the credit is much lower than the amounts they would need to buy typical plans available in today's market. This would leave families, even after the credit, with thousands of dollars in annual premiums and out-of-pocket costs.

Fortunately, there are alternatives to the President's proposal. In the House, a variety of bills have been introduced, including proposals for a single payer program, and bills -- like my own and Chairman Rostenkowski's -- that use an employer choice model supplemented by a strong public plan.

The Waxman Proposal

I'm sure you're familiar with the proposal I've introduced. It's based on the recommendations of the Pepper Commission that was chaired by Senator Jay Rockefeller.

Basically, it's an employer choice bill.

Employers would be required to offer coverage to workers and their families, but they would have a choice in how they did so. They could either purchase private policies, administer their own plans, or enroll their employees in a new Medicare-like public program.

For people who are outside the workforce, the bill would provide coverage through the new public program -- a program which would be completely independent of Medicaid and the welfare system.

The elderly would continue to receive coverage through Medicare.

The poor would receive coverage for basic health services under either the new public health insurance plan or through their employers. Medicaid benefits like prescription drugs that are not included in the basic services package would continue to be offered through the current Medicaid program under existing rules. Current State spending for Medicaid coverage for hospital, physician, lab, and other basic health services would be phased out, with the Federal government assuming the entire cost.

Single Payor and Compromise

There are other strong approaches to health care reform. Chairman Dingell has introduced a single payor plan financed by a value added tax, or VAT. Mr. Russo has introduced a Canadian-style single payor bill that has a large number of cosponsors in the House.

My view has always been that, while employer choice and single payor plans are different, they share the common objectives of universal coverage and cost containment.

We just can't allow the differences between these approaches to block achievement of health reform, because it is clear to me that either of these approaches is clearly superior to the status quo.

During the last few weeks I have been exploring with Chairman Dingell a health reform proposal that the Energy and Commerce Committee could report. We have agreed to work together to develop a plan with universal coverage and strong cost controls. We hope to have more details on this available soon.

Stand-Alone Small Business Reform

Let me tell you what I couldn't support. I was very disturbed by the decision of the Senate Finance Committee to include small business insurance regulation in the tax bill that is being cleared for the White House today.

As I mentioned earlier, the small group market is collapsing in a frenzy of medical underwriting and experience rating. But it can't be fixed without addressing other problems in the system -- especially health care costs.

The Finance Committee proposal would not contain the price of health care services, which is driving up small group insurance premiums. By ignoring health care costs, the proposal would actually make lots of people who now work for small employers much worse off, because it could well result in hefty increases in premiums for many relatively healthy groups.

The Finance Committee proposal would not bring real help to most of the uninsured, since it does not provide resources to help them afford basic coverage. Incredibly, it does manage to provide Federal grants that can be used for sales commissions to insurance agents.

The Finance Committee proposal attempts to set minimum Federal standards for small group insurance products. There's no doubt that minimum Federal standards are needed. The problem is that the Committee's standards fall well short of what I -- and the Pepper Commission -- thought was a reasonable set of protections for consumers. I'm especially concerned that the standards for benefits would allow clearly inferior products to remain on the market -- but now with a Federal "Good Housekeeping" seal of approval.

And worst of all, I fear that enactment of this proposal -- which is designed to phase in over the next 6 years -- would have been used by opponents of comprehensive reform as a excuse for inaction. We simply can't wait until 1998 to enact legislation that actually controls health care costs and provides universal coverage.

For all these reasons, I am pleased that the tax conferees have agreed to drop all of these provisions out of the bill going to the President later today. It is now my expectation that the House Committees with legislative responsibility for health care reform will move ahead to consider comprehensive measures this spring.

Conclusion

The solutions to these problems will not come easily or quickly. Any meaningful reform will change the way we finance health care services, and many of us will face additional burdens. But, as we consider the costs of change, we must recognize the even larger costs to our society if we fail to act. Every day that we delay, more Americans go without needed care and the costs of services push insurance coverage beyond the means of more working people and their families. Waiting will not make these problems easier or cheaper to solve.

I hope we can work with the White House in fashioning a comprehensive plan that meets our reform goals. Surely we can find a way to end the disgrace of millions of Americans without access to decent, affordable health care.

I look forward to your help and advice. And, I thank you for the chance to talk with you about these critical issues.